Return form to:
INDIANA STATE BOARD OF
HEALTH FACILITY ADMINISTRATORS
Health Professions Bureau
402 West Washington Street, Room W066
Indianapolis, IN 46204
Telephone number: (317) 234-2051

Email address: hpb6@hpb.in.gov

* THIS FORM IS FOR <u>ENDORSEMENT CANDIDATES</u> ONLY.

	APPLICANT INFORMATION			
Name (last, first, middle, maiden)			Social Security number*	
Address (number and street, city, state, ZIP code)				
License number	Date of issuance (month, day, year)		Date of birth (month, day, yea	ar)
I hereby authorize	to fu	rnish the Health Profe	essions Bureau with the inf	formation below.
Signature of applicant			Date (month, day, year)	
THIS SECTION IS	TO BE COMPLETED AND AUTHORIZ	PED BY THE STATE	BOARD	
	above completed an administrator-in-tra			
Name of facility where training took place		Length of training program		
			months	hours
Address (number and street, city, state, ZIP code)				
Preceptor / Supervisor of training program				
Type of facility				
Form completed by (printed name)		1	Please affix Board seal	
Title		1	riease allix doard seal	
Signature	Date (month, day, year)	1		